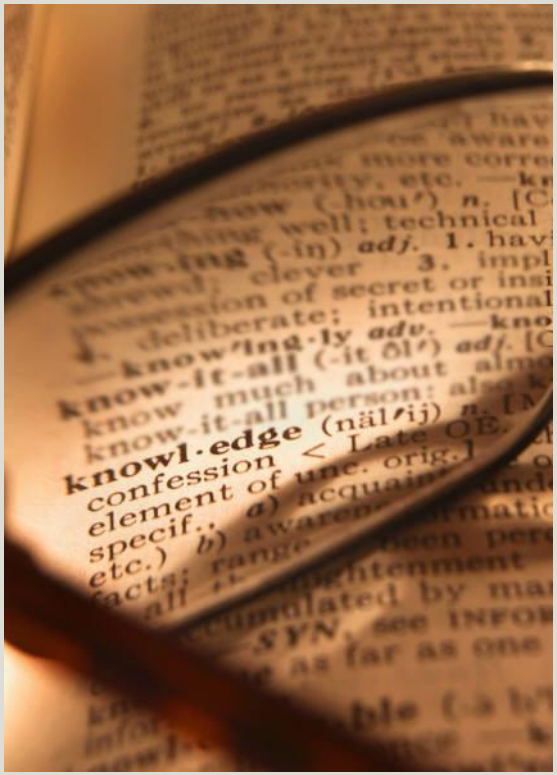
# Health Care Finance 101




**Ken Tonjes**
**CFO PeaceHealth Ketchikan Medical Center**

**June 20, 2013**

# Common Financial Terminology

**Gross Charges (Revenue) –** Total Patient Revenue generated (price x quantity**)**

**Deductions from Revenue –** Amount of gross charges not collected due to
- uncompensated care – charity and bad debt
- contractual allowances – difference between charges and payments for all payers

**Net Patient Service Revenue –** Total amount of cash collected from gross charges

**Income From Operations -** Total Operating Revenue less Total Operating Expense (operations bottom line)

**Non Operating Revenue -** Income from Non Operating Activities – such as investments, gains/losses on disposal of assets, etc.

**Net Income (Excess of Revenue over Expense) -** Income from Operations plus Non Operating Revenue

**Days of Cash –** Cash and Investments/ Average daily cash expenses

**Price/Payment/Cost –** Different Definition for provider vs payer vs patient

# Hospital Types

**Hospitals register with American Hospital Association as one of these 4 types:**

**(1) General -** Provides both diagnostic and therapeutic patient services for a variety of medical conditions

**(2) Specialty -** A specialty hospital is generally defined as a type of hospital that restricts its admissions to a particular group of persons or class of services (Surgical Centers e.g.)

**(3) Rehab and Chronic Diseases* -** Provides diagnostic and treatment services to disabled individuals requiring restorative and adjustive services

**(4) Psychiatric* -** Provides diagnostic and treatment services for patients who require psychiatric –related services

***Can be set up as sub units within hospitals**

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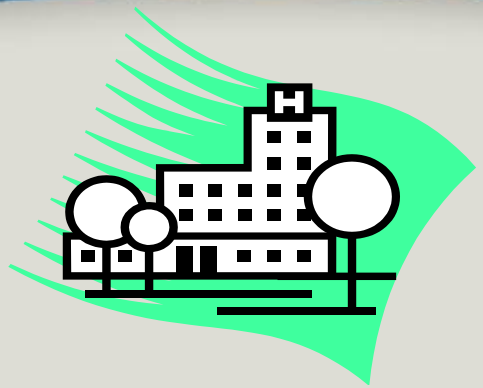
# Hospital Organization Structures



- **Public -** 2 types
  - Federal - run by the Military or VA
  - Non- Federal - funded in part by a city, county, tax district or State

    *** 21% in US ** 5% in Alaska**

- **Not-for-Profit -** Tax exemption in exchange for providing charitable services

  *** 58% in US ** 86.5% in Alaska**

- **For Profit (Investor-Owned) -** Have shareholders, pay income tax , still provide charitable services

  *** 21% in US **8.5% in Alaska**

*** AHA Annual Survey 2011**
**** ASHNHA June 2013**

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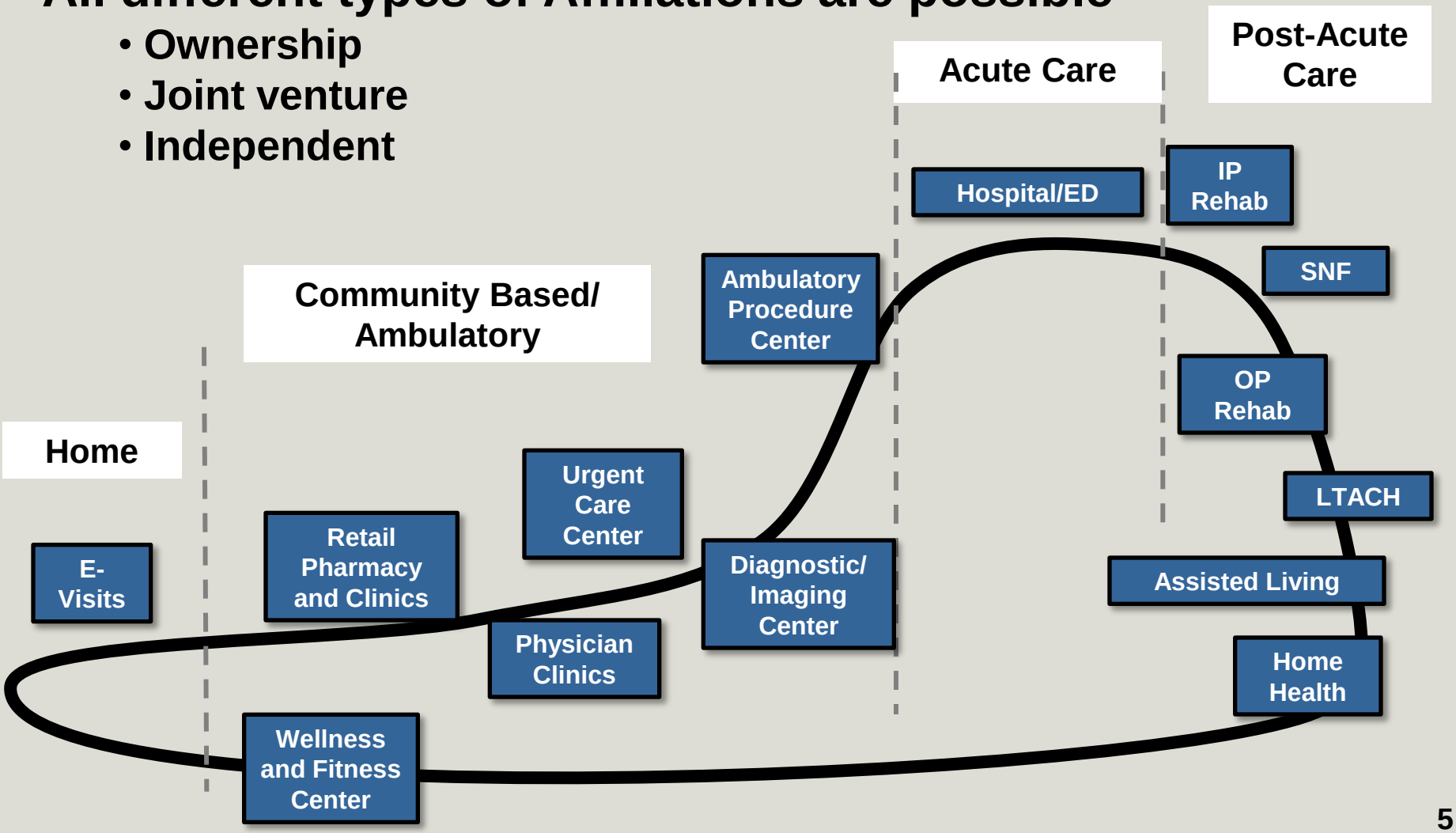
# Health Care Providers

## All different types of Affiliations are possible

- Ownership
- Joint venture
- Independent



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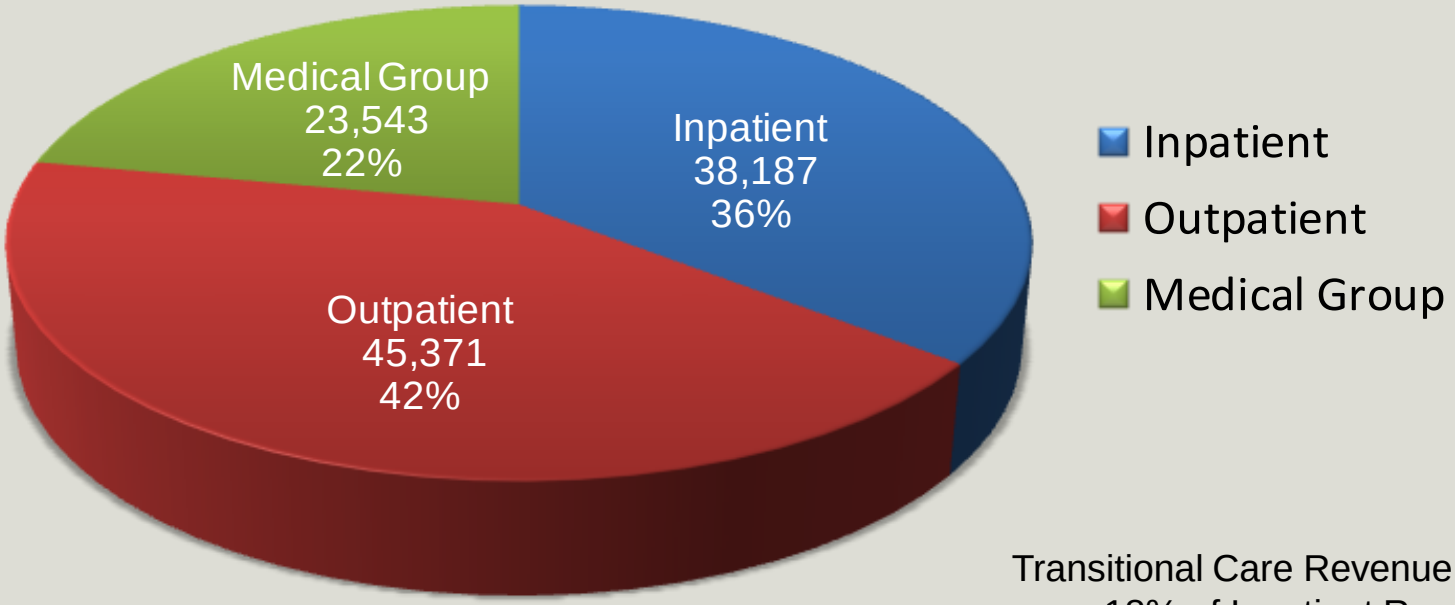
# Health Care Revenue

# Revenue Mix

## Total Patient Service Revenue: $107,101
**(000's Omitted)**




Transitional Care Revenue makes up 18% of Inpatient Revenue

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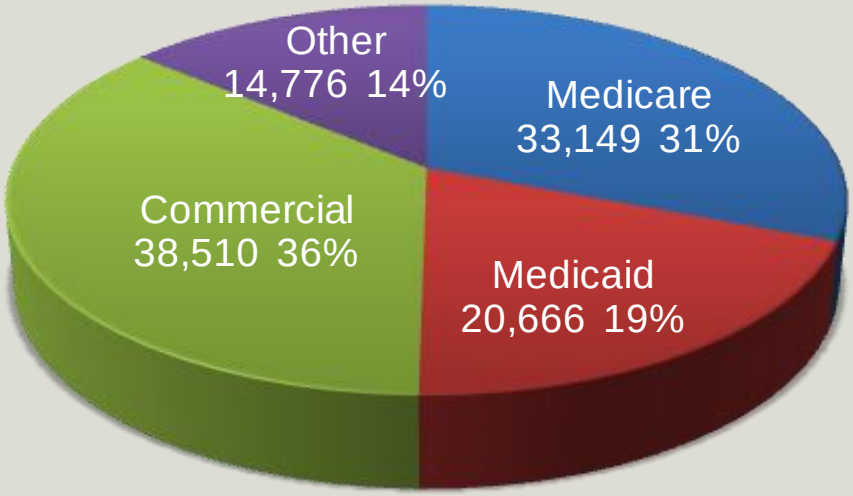
# KMC Payer Mix and Payments

| | | |
|---|---|---|
| Gross Charges | = | 107,101 |
| Deductions | = | 42,619 |
| Payments | = | 64,482 |

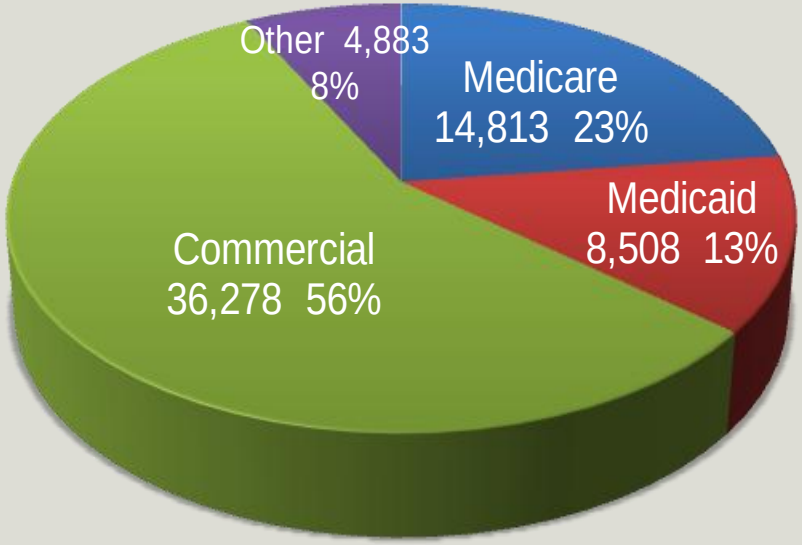
(000's omitted)

| | | |
|---|---|---|
| Deduction % | = | 40% |
| Payment % | = | 60% |

## Gross Revenue Payer Mix




## Payments




**Commercial makes up 36% of Gross Revenue yet accounts for 56% of Payments**

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# Hospital Price Setting

**Most health care providers use a hybrid approach incorporating aspects of both resource based and market based methodologies in setting prices.**

**Resource Based**

- RVU's - Diagnostics

  Medicare RVU weights multiplied by a conversion factor

| CPT | Description | RVU's | | Conversion Factor | | Price |
|---|---|---|---|---|---|---|
| 73100 | X-RAY EXAM OF WRIST | .92 | ✖ | 215 | = | 197.8 |

- Cost - Room Charge
- Mark Up - Supplies and Drugs
- Time Studies - OR Minute Charges

**Conversion Factor – must cover both costs and margin requirements (deductions from revenue and profit)**

**Market Based Adjustments**

- Competition
- Payer Mix/Payer Contracts
- Loss Leaders

**Theoretical – each procedure unique CF**
**Practical – overall CF applied, or hospital/Medical Group**

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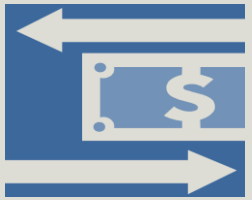
# Colonoscopy

| Procedure | Colonoscopy Alone | Total Charges For Colonoscopy |
|---|---|---|
| Colonoscopy W Or Wo Bx | 1,020 | 4,717 |
| Colonoscopy With Polypectomy | 1,190 | 7,106 |

| Procedure | Colonoscopy Alone | Ancillary Charges | Physician Fees | Anesthesia | Pathology |
|---|---|---|---|---|---|
| Colonoscopy W Or Wo Bx | 1,020 | 1,879 | 395 | 1,198 | 225 |
| Colonoscopy With Polypectomy | 1,190 | 2,506 | 1,987 | 1,198 | 225 |

Ancillary Charges include: Recovery room, pharmacy, etc.

# Cost Shifting



Cost Shifting in simple terms is the practice of raising overall prices to improve payment from a group of payers (Commercial) to offset payment shortfalls from other payers (Medicare/Medicaid, Self Pay)


Commercial Pays 3 times Medicare
to achieve margin of 2%

# Service Mix

## Negative Margins

- Medical Group
- Transitional Care Unit
- Home Health
- Intensive Care Unit
- Emergency Department
- Therapies

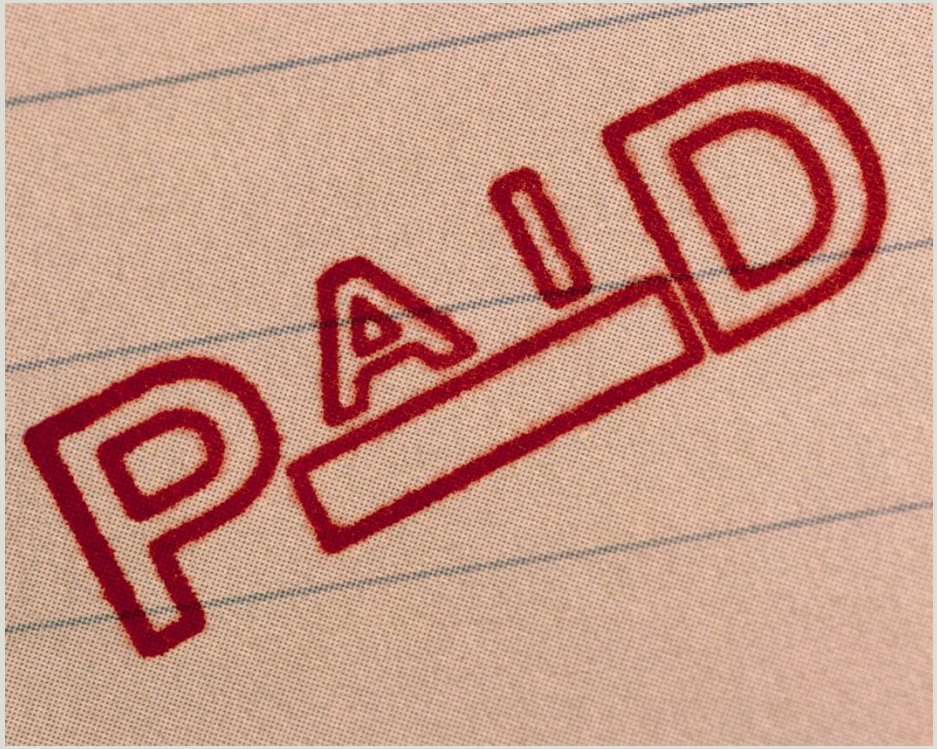
## Positive Margins

+ Imaging
+ Surgery
+ Pharmacy
+ Women's Health
+ Lab
+ Pathology


**Positive Margin Service Lines subsidize Negative Margin Service lines**

**Traditionally, Surgery and Imaging Service Lines most profitable**

# Payment Mechanisms



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# Medicare Payment Methodologies
## Quick Overview

### Medicare
**Hospital PPS**

| | Reimbursement Methodology | | |
|---|---|---|---|
| Inpatient | DRG | Prospective Payment System | Relative Weight of DRG x Base Rate |
| Outpatient | APC | Prospective Payment System | |

**Critical Access Hospital**

| | | | |
|---|---|---|---|
| Inpatient | Cost | Calculated from Medicare Cost Report | |
| Outpatient | Cost | Calculated from Medicare Cost Report | |

**Sole Community Hospital**

| | | | |
|---|---|---|---|
| Inpatient | Cost | Calculated from Base year cost per discharge inflated forward | |
| Outpatient | APC | Prospective Payment System | |

| | | | |
|---|---|---|---|
| **Skilled Nursing Facility** | RUGS | Prospective Payment System | Per Discharge |

**Physician Clinics**

| | | |
|---|---|---|
| Provider Based Clinics | Hospital Outpatient Departments | Follow methodology for Hospital Outpatient Type |
| Freestanding Clinics | Fee Schedule | |

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# Medicare - IP

**Sample Case:**
DRG 194 SIMPLE PNEUMONIA & PLEURISY W CC
Weight = 0.9996
Total Charges = $16,082.00

## CAH Reimbursement:

| Department | Charges | | Payment |
|---|---|---|---|
| **Routine Charges** | | **Per Diem** | |
| Room Charge (LOS 3) | 6,066.00 | 1,898 | 5,694.00 |
| **Ancillary Charges** | | **RCC** | |
| Lab | 660.10 | 48% | 316.85 |
| CT | 2,585.20 | 48% | 1,240.90 |
| Radiology | 354.40 | 48% | 170.11 |
| Pharmacy | 1,866.40 | 48% | 895.87 |
| Respiratory | 4,549.90 | 48% | 2,183.95 |
| **Total** | **16,082.00** | | **10,501.68** |

Contractual Adjustment = $5,580.32

## SCH Reimbursement:

DRG Weight .9996
X
Hospital Specific Base Rate $7,478.14
=
$7,475.15

Contractual Adjustment = $8,606.85

## PPS Reimbursement:

DRG Weight .9996
X
Base Rate $7,040.99
=
$7,038.17

Contractual Adjustment = $9,043.83

The DRG payment for a Medicare patient is determined by multiplying the relative weight for the DRG by the hospital's blended rate: DRG PAYMENT = WEIGHT x RATE

- The weight indicates the relative costs for treating patients
- The Base Rate is defined by Federal regulations and includes Operating and Capital Payments with local adjustments for: Wage Index, Geographic Factor, Disproportionate share of financially indigent patients

# Medicare - OP

**CPT Based Payment: Outpatient Services (Imaging, PT, ED, etc)**

| CPT | Description | Charge Amount | PPS/SCH Payment | CAH Payment |
|---|---|---|---|---|
| 93017 | CARDIAC STRESS W/O INTERP | $ 375.70 | $178.58 | $ 180.34 |
| A9579 | NM MYO PERF W SPECT/WALL/EF | $2,186.10 | $686.45 | $1,049.33 |
| **TOTAL** | | **$2,561.80** | **$865.03** | **$1,229.67** |
| | | | APC Payment | Cost Reimbursement: Charge x RCC |

The APC payment for a Medicare patient is determined by multiplying the relative weight for the APC by the adjusted conversion factor:

APC PAYMENT = WEIGHT x CONVERSION FACTOR

Outpatient services are grouped into ambulatory payment classifications (APCs) on the basis of clinical and cost similarity.

The relative weight for an APC measures the resource requirements of the service and is based on the median cost of services in that APC.

The conversion factor is adjusted for geographic differences and the hospital wage index.

# Medicare pays for Clinic Charges Based on each billed CPT Code

**Clinic charges are reimbursed 3 different ways:**

1. Free Standing Clinic
2. OPPS Provider Based Entity
3. CAH with Method II

HNPRDS13 ALASKA - MEDICARE CARRIER 02102 PAGE 145
FSY13 LOCALITY FEE SCHEDULE FOR AREA 01 DATE 01/09/13

| NOTE | PROCEDURE | MOD | PAR AMOUNT | NON-PAR AMOUNT | LIMITING CHARGE | eRX LIMITING CHARGE*** |
|---|---|---|---|---|---|---|
| | 73100 | | 37.38 | 35.51 | 40.84 | 40.23 |
| | 73100 | TC | 25.64 | 24.36 | 28.01 | 27.59 |
| | 73100 | 26 | 11.74 | 11.15 | 12.82 | 12.63 |

**CPT Based Payment:**

1. FSC - Physician Fee Schedule Global Payment = Facility + Professional
2. OPPS PBE - Facility Portion paid based on APC and Professional Portion paid based on Physician Fee Schedule
3. CAH with Method II – Facility Portion paid based on Cost and Professional Portion paid based on Physician Fee Schedule plus 15%

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# Medicaid Payment Methodologies

## Medicaid

| Hospital | Reimbursement Methodology | | |
|---|---|---|---|
| Inpatient | Per Diem | Cost Based from Base year Medicare Cost Report | Rebased every four years 2011--> 2013-2016 |
| Outpatient | % of Charges | Cost Based from Base year Medicare Cost Report | Rebased every four years 2011--> 2013-2016 |

| Skilled Nursing Facility | | | |
|---|---|---|---|
| SNF | Per Diem | Cost Based from Base year Medicare Cost Report | Rebased every four years 2011--> 2013-2016 |

| Physician Clinics | |
|---|---|
| Provider Based Clinics | Fee Schedule |
| Freestanding Clinics | Fee Schedule |

**Inpatient:**

Medicaid Days
x
Per Diem
=
IP Medicaid Payment

**Outpatient:**

Charges
x
RCC
=
OP Medicaid Payment

**Clinic:**

Table I.(a) CPT [1] Fee Schedule

| Procedure | | Modifier | Alaska Fee |
|---|---|---|---|
| 73100 | **Global** | | $47.84 |
| 73100 | **Pro** | 26 | $15.33 |
| 73100 | **Fac** | TC | $32.51 |

# Commercial Payment Methodologies

## Commercial Payers Pay Based on:

- Percentage of Charges
- Case Rate
- Fee Schedule
- Per Diem
- Capitated

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# Health Care Costs

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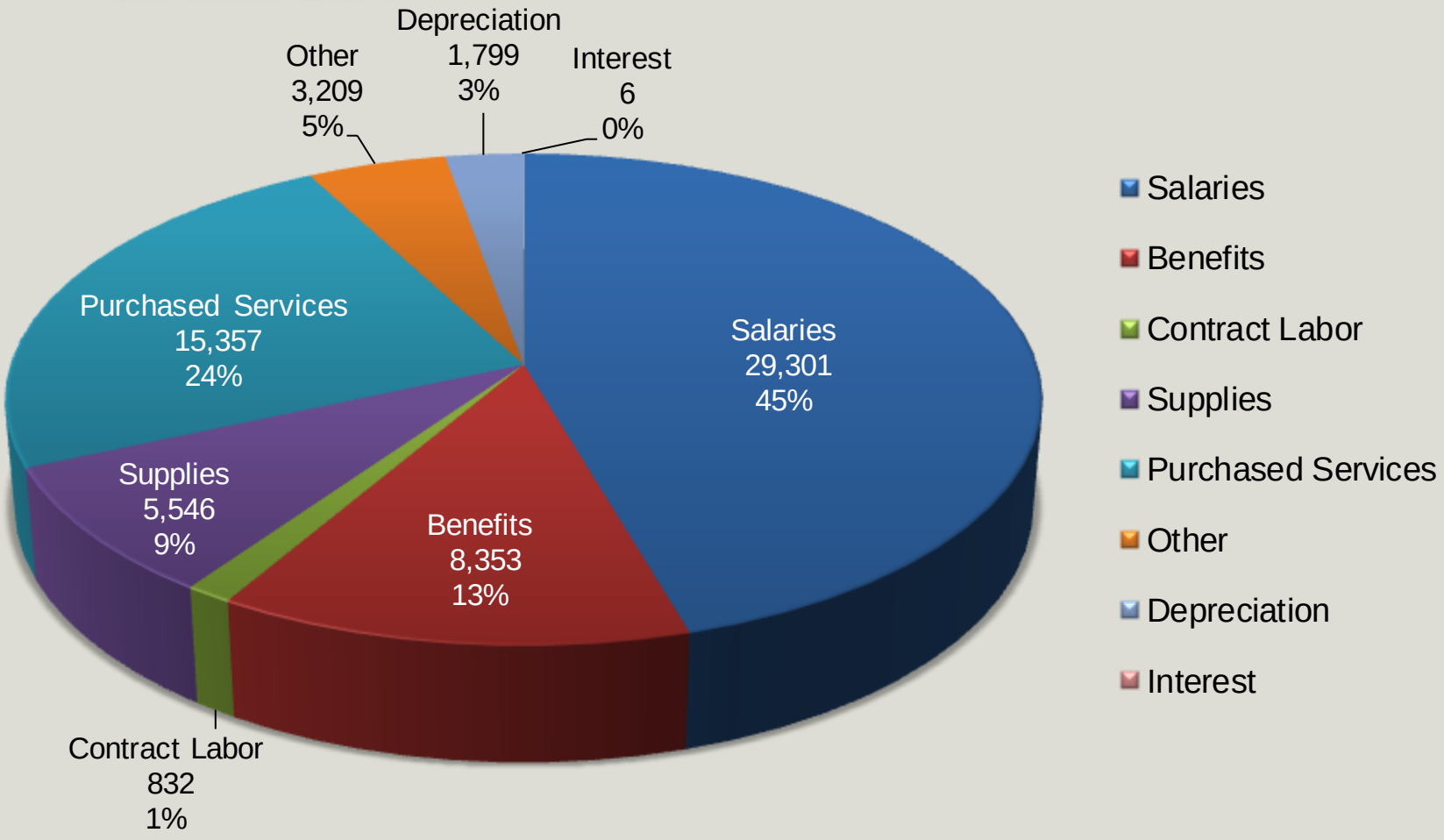
# Operating Costs

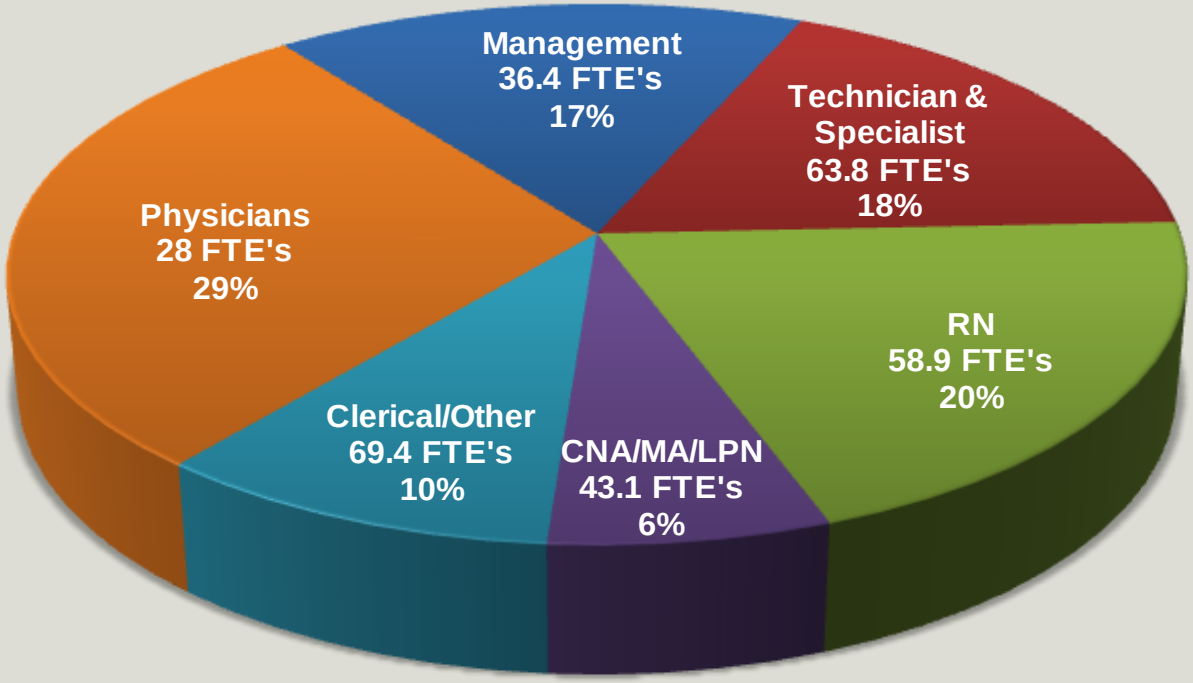



**Labor Costs (Salaries, Benefits, and Contract Labor) = 59%**

# Labor Costs

## Wage Observations

- Two thirds of labor costs are clinical
- Physicians – Starting point MGMA Median plus 15%



# Healthcare Salaries

## What a difference an education can make!

| Career | Years Post HS | Median Gross $ at the 50th percentile of the market |
|---|---|---|
| RN | 2-4 Years | $80,000 |
| Rad Tech | 2 years | $62,000 |
| Ultrasound Tech | 2 years | $82,000 |
| Med Tech (Lab) | 4 - 5 years | $68,000 |
| Nurse Practitioner/ Physician Assistant/ CNM/CRNA | 6 -8 years | $110,000 - $192,000 |
| Physical Therapist | 6 - 8 years | $82,000 |
| Pharmacist | 6 - 8 years | $120,000 |
| Physician | 10+ years | $250,000 - $600,000+ |

# Cost Pressures

## Alaska Providers face different challenges:

- **Contract Labor -** Essential staff (Providers, nursing, clinical, etc.) terminate, requiring coverage through agency staffing at a premium (35-100%)
- **Recruitment /Retention -** Costs to recruit high, long duration, limited labor pool
- **Cost of Living -** Higher in Alaska, requires higher wages and moving allowances
- **Lower volumes -** Lower volumes restrict efficiency resulting in lower productivity
- **Supply costs -** Barged or flown in to all Alaskan communities
- **Construction Costs -** 25% higher in Alaska than lower 48 ($300/sq ft vs $240/sq ft)

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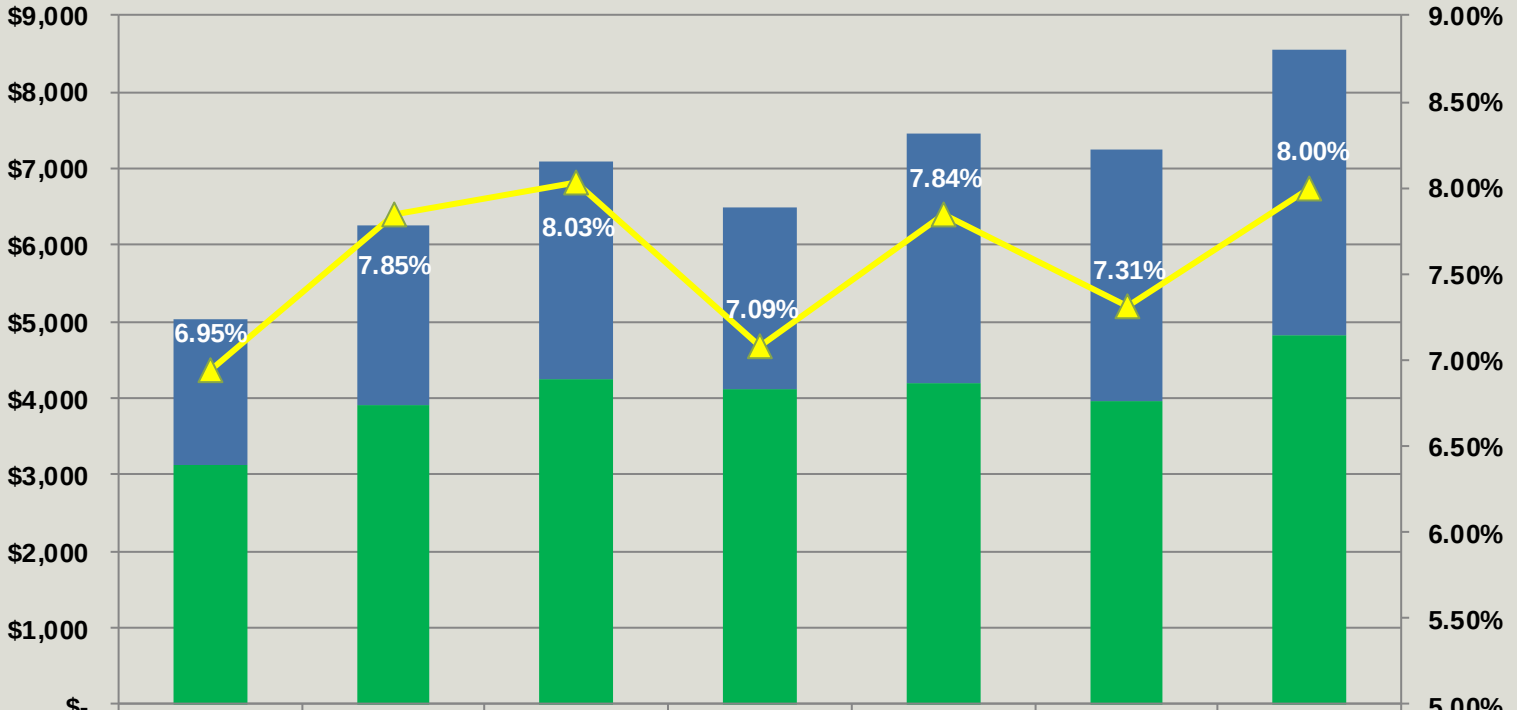
# Bad Debt and Charity Trend




| (000's omitted) | 2008 Actual | 2009 Actual | 2010 Actual | 2011 Actual | 2012 Actual | 2013 Projected | 2014 Budget |
|---|---|---|---|---|---|---|---|
| Charity | $1,916 | $2,350 | $2,856 | $2,360 | $3,243 | $3,280 | $3,749 |
| Bad Debt | $3,122 | $3,914 | $4,241 | $4,129 | $4,205 | $3,964 | $4,820 |
| Total Uncomp Care | $5,038 | $6,264 | $7,097 | $6,489 | $7,449 | $7,245 | $8,568 |
| % of Gross Charges | 6.95% | 7.85% | 8.03% | 7.09% | 7.84% | 7.31% | 8.00% |

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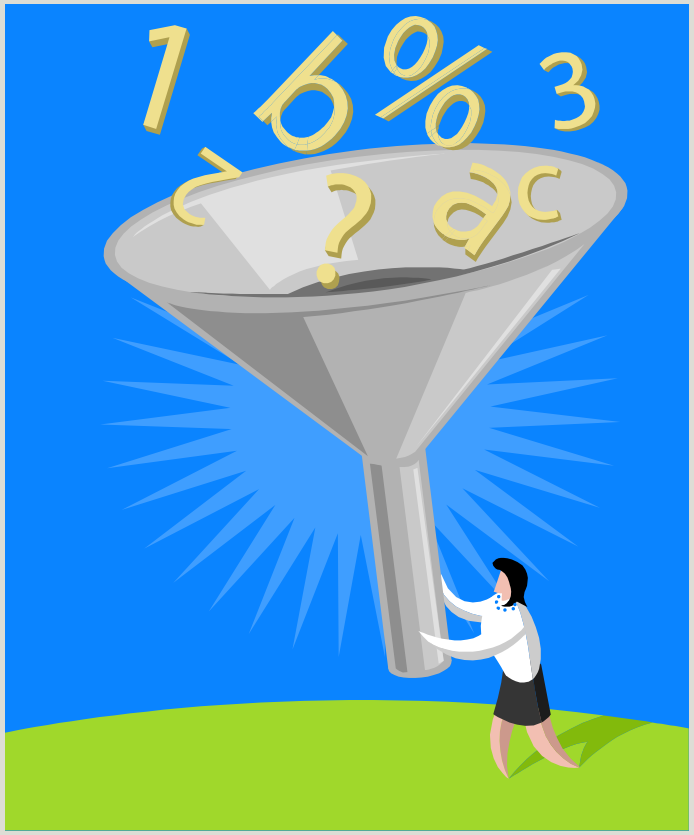
# Other Information



# Charge Master - What it is and What it Does

## What is a Charge Description Master?

The Charge Description Master (CDM) is *primarily* a list of services/procedures, room accommodations, supplies, drugs/biologics, and/or radiopharmaceuticals that may be billed to a patient registered as an inpatient or outpatient on a claim.

## The CDM may also contain/be used for the following:

- Statistical tracking line items
  - Used to capture labor for budgetary purposes
  - No dollars, CPT/HCPCS or revenue code attached
- Payment and adjustment codes

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# Charge Master Common Elements

**The core group of data elements that typically resides within a CDM are:**

| | Example: |
|---|---|
| • CDM numbers | 30000612 |
| • Charge Descriptions | XR WRIST RIGHT 2 VIEWS |
| • Charge amounts | $186.10 |
| • Revenue codes | 320 |
| • Department numbers | 41400 |
| • CPT/HCPCS codes | 73100 |
| • Modifiers | RT |
| • Relative Value Units (Statistical measures) | 0.71 |

5600 charge items on KMC's charge master

# Cost Report

**Medicare Cost Reports -** An annual report required of all institutions participating in the Medicare program, which records each institution's total costs and charges associated with providing services, the portion of those costs and charges allocated to Medicare patients, and the Medicare payments received.

**The cost report contains provider information such as:**

- Facility characteristics
- Utilization data
- The cost and charges by cost center (in total and for Medicare)
- Medicare settlement data
- Financial statement data.

**Primary reimbursement determined via the cost report for:**

| **CAH** | **PPS/SCH** |
|---|---|
| Calculate Cost Based Reimbursement | • Bad Debt<br>• Disproportionate Share<br>• Medical Education |

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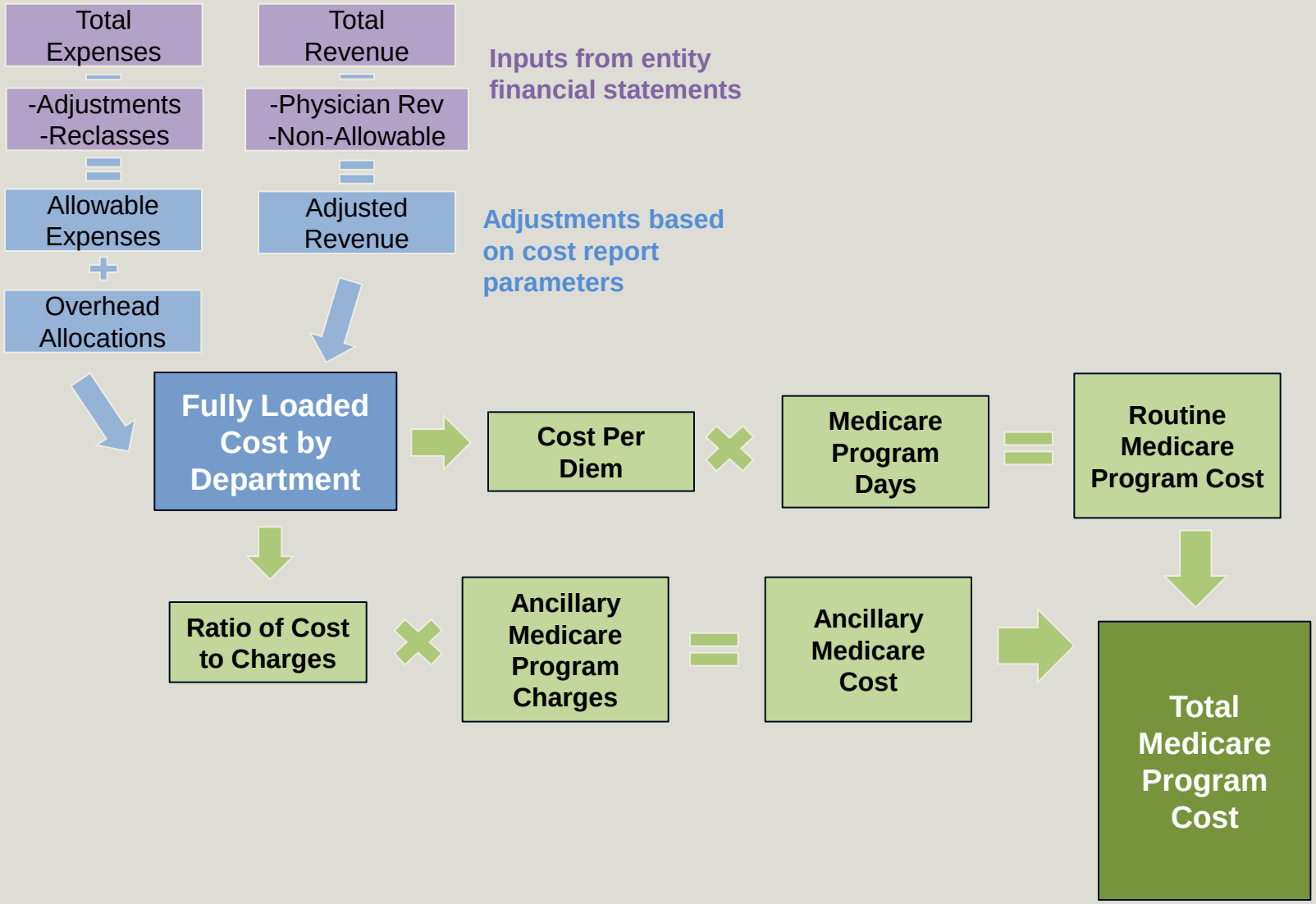
# Cost Report Flow Chart



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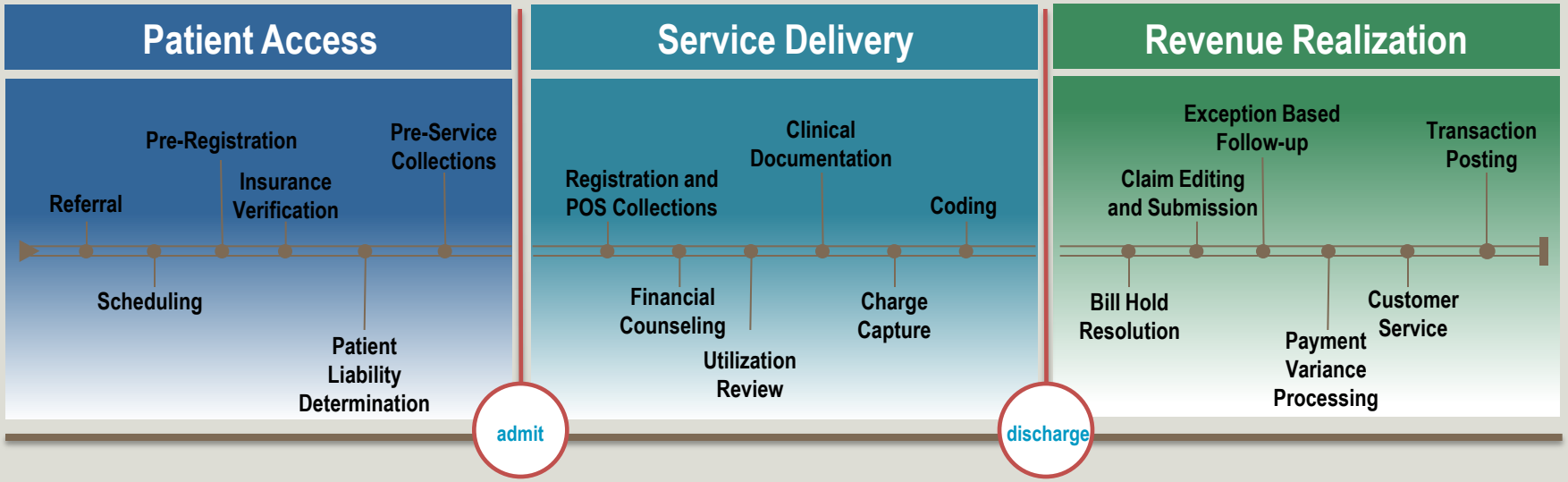
# Revenue Cycle



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# Trends Influencing Health Care

| Trend | Penalty | Hospitals Impacted | Date |
|---|---|---|---|
| ICD-10 | Requirement 10/1/14 | All | 10/1/14 |
| Inpatient Quality Reporting | 2% | IPPS | FY12 |
| OP Quality Reporting | 2% | OPPS | FY12 |
| Value Based Purchasing | 2% | IPPS | 1% FY13→2%FY17 |
| Hospital Acquired Conditions /Present on Admission | 1% | IPPS | 1% FY15 |
| Readmissions | 3% | IPPS | FY13, 3 Year Phase-In |
| Meaningful Use | Loss of Incentive | All | 10/1/12 |
| HIPAA 5010 | Denied Claims | All | 10/1/12 |
| ACA | All Must Comply | All | |

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# Presentation Summary

## Health Care Finance is complicated due to:

- Each input is unique, therefore care delivery must be flexible (variable)
- Physician orders drive provision of care adding to that variability
- Payment is also variable depending on:
  - Insurance coverage
  - Negotiated Rates
  - Payer Mix

- Regulation is high
- Technology changes rapidly requiring intensive capital investment
- Many players in Health Care, from capital equipment vendors to Pharmaceutical companies to agency staffing making it difficult to control all aspects of Costs